## Morgan Chiropractic, Inc.

# REGISTRATION FORM

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| --- |
| PATIENT INFORMATION |
| Patient’s last name: | First: | Middle: | Marital status (circle one) |
|  | Single / Married / Divorced / Separated / Widowed |
| Birth date: | Age: | Sex: | Social Security no.: |  |
|  / / |  | ❑ M | ❑ F |  |  |
| Street address:  |  | Phone no.: |
|  |  | ( ) |
| City: | State: | ZIP Code: | Email: |
|  |  |  |  |
| Occupation: | Employer: | Employer phone no.: |
| Chose clinic because/Referred to clinic by (please check one box): | ❑ Dr. |  | ❑ Insurance Plan | ❑ Hospital |
| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Internet | ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| INSURANCE INFORMATION |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
|  |  / / |  | ( ) |
| Occupation: |  | Employer: |
| Is this patient covered by insurance? | ❑ Yes | ❑ No |  |
| Primary insurance name: |  |
| Subscriber’s name: |  | Birth date: |  / / | Group no.: |  | Policy no.: |  |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
| Name of secondary insurance (if applicable): |  | Group no.: | Policy no.: |
| Subscriber’s name: |  | Group no.: |  | Policy no.: |  |
| **\*If an auto accident please provide:** |
| Insurance Company Name: | Contact Person: | Phone no.: | Claim # |
|  |  | ( ) |  |
| Signatures |
| Name of Insured: |  |  |  |
| In exchange for Morgan Chiropractic, Inc.’s forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustors responsible for claims filed by me, administrative agencies, the Alaska Workers’ Compensation Board, and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgement, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority. I specifically request that any amount authorized to be paid to me by an insurance company, employer, or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all of my indebtedness, I will remain liable to Morgan Chiropractic, Inc. for the balance, including finance charges and collection expenses. I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Morgan Chiropractic, Inc. are fully paid.  |
| *Patient or Guardian Signature:*  |  | *Date* |  |

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| --- |
| **CURRENT COMPLAINTS** |
| Nature of Injury | [ ] Automobile | [ ] Work | [ ] Other: |  |
| Please Describe |  |
|  |
| Date of Injury:  |  | Date symptoms appeared: |  |
| Have you ever had this same condition? | [ ] Yes | [ ] No | If yes, when? |  |
| List of practitioners seen for this injury/condition: |  |
| Have you ever been under chiropractic care? | [ ] Yes | [ ] No |  |
| If yes, please describe:  |  |
| **MEDICAL HISTORY** |
| Have you been treated for any conditions in the last year? | [ ] Yes | [ ] No |  |
| If yes, please describe: |  |
| Date of last physical exam |  | Is there a chance that you are pregnant? | [ ] Yes | [ ] No |
| Have you had X-Rays taken? | [ ] Yes | [ ] No | If yes, where? |  |
| What medications are you taking and for what conditions? (Please list dosage and amounts, etc.) |
|  |
|  |
| What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency) |
|  |
|  |
| **HAVE YOU EVER:** | **YES** | **NO** | **BRIEFLY EXPLAIN** |
| Broken Bones? |[ ] [ ]   |
| Been hospitalized? |[ ] [ ]   |
| Been in an auto accident? |[ ] [ ]   |
| Had sprains/strains? |[ ] [ ]   |
| Been struck unconscious? |[ ] [ ]   |
| Had surgery? |[ ] [ ]   |
|  |
| **FAMILY HISTORY** |
| Family members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.) |
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|  |
|  |
| **PAIN AND SYMPTOMS** |
| Do you experience pain every day? | [ ] Yes | [ ] No |  |
| Do your symptoms interfere with daily life? | [ ] Yes | [ ] No |  |
| Does pain wake you up at night? | [ ] Yes | [ ] No |  |
| Are your symptoms worse during certain times of the day? | [ ] Yes | [ ] No |  |
| Do changes in weather affect your symptoms? | [ ] Yes | [ ] No |  |
| Do you wear orthotics? | [ ] Yes | [ ] No |  |
| Do you take vitamin supplements? | [ ] Yes | [ ] No |  |
| What activities aggravate your symptoms? |
|  |
| **HABITS** | **NONE** | **LIGHT** | **MODERATE** | **HEAVY** |
| Alcohol |[ ] [ ] [ ] [ ]
| Coffee |[ ] [ ] [ ] [ ]
| Tobacco |[ ] [ ] [ ] [ ]
| Drugs |[ ] [ ] [ ] [ ]
| Exercise |[ ] [ ] [ ] [ ]
| Sleep |[ ] [ ] [ ] [ ]
| Appetite |[ ] [ ] [ ] [ ]
| Soft Drinks |[ ] [ ] [ ] [ ]
| Water |[ ] [ ] [ ] [ ]
| Salty Foods |[ ] [ ] [ ] [ ]
| Sugary Foods |[ ] [ ] [ ] [ ]
| Artificial Sweeteners |[ ] [ ] [ ] [ ]
|  |
| **REVIEW OF SYSTEMS** |
| Have you had any of the following **constitutional** issues? |
| [ ] Chills | [ ] Weight gain | [ ] Weight loss | [ ] Fatigue | [ ] Daytime somnolence (drowsiness) | [ ] Night sweats | [ ] Fever |
| [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **eye** issues? |
| [ ] Blindness | [ ] Eye pain | [ ] Double vision | [ ] Photophobia | [ ] Tearing | [ ] Blurred vision | [ ] Field Cuts (visual field defect) |
| [ ] Cataracts | [ ] Glaucoma | [ ] Change in vision | [ ] Itching (around eyes) | [ ] Wear glasses/contact lenses |
| [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **ENT** issues? |
| [ ] Bleeding | [ ] Discharge | [ ] Dizziness | [ ] Snoring | [ ] Fainting | [ ] Headaches | [ ] Loss of smell | [ ] Sore throats (frequent) |
| [ ] Nasal congestion | [ ] Sinus infections | [ ] Dental implants | [ ] Ear drainage | [ ] Ear infection(s) | [ ] Hearing loss | [ ] Tinnitus |
| [ ] Post nasal drip | [ ] Difficulty swallowing | [ ] Ear pain | [ ] Hoarseness | [ ] Rhinorrhea (runny nose) | [ ] Sinus infection(s) |
| [ ] TMJ problems | [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **female** issues? |
| [ ] Birth control therapy | [ ] Breast lump/pain | [ ] Cramps | [ ] Burning urination | [ ] Frequent urination | [ ] Urine retention |
| [ ] Hormone therapy | [ ] Irregular menstruation | [ ] Vaginal bleeding | [ ] Vaginal discharge | [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **male** issues? |
| [ ] Burning Urination | [ ] Frequent urination | [ ] Urination retention | [ ] Hesitancy/dribbling | [ ] Prostate issues | [ ] Erectile dysfunction |
| [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **respiratory** issues? |
| [ ] Asthma/difficult breathing  | [ ] COPD | [ ] Emphysema | [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **cardiovascular** issues or procedures? |
| [ ] Heart Surgeries | [ ] Congestive heart failure | [ ] Murmurs or valvular disease | [ ] Heart attacks/MIs | [ ] Heart disease/problems |
| [ ] Hypertension | [ ] Pacemaker | [ ] Angina/chest pain | [ ] Irregular heartbeat | [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **gastrointestinal** issues? |
| [ ] Nausea | [ ] Difficulty swallowing | [ ] Ulcerative disease | [ ] Frequent abdominal pain | [ ] Hiatal hernia | [ ] Constipation |
| [ ] Pancreatic disease | [ ] Irritable bowel/colitis | [ ] Hepatitis or liver disease | [ ] Bloody or black tarry stools | [ ] Vomiting blood |
| [ ] Bowel incontinence | [ ] Gastroesophageal reflux/heartburn | [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **musculoskeletal** issues? |
| [ ] Rheumatoid arthritis | [ ] Gout | [ ] Osteoarthritis | [ ] Broken Bones | [ ] Spinal fracture | [ ] Spinal surgery | [ ] Joint surgery |
| [ ] Arthritis (unknown type) | [ ] Scoliosis | [ ] Metal implants | [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **integumentary (dermatological)** issues? |
| [ ] Significant burns | [ ] Significant rashes | [ ] Skin grafts | [ ] Psoriatic disorders | [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **neurological** issues? |
| [ ] Visual changes/loss of vision | [ ] One-sided weakness of face or body | [ ] History of seizures | [ ] One-sided decreased feeling in face or body |
| [ ] Headaches | [ ] Memory loss | [ ] Tremors | [ ] Vertigo | [ ] Loss of sense of smell | [ ] Strokes/TIAs |  |
| [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **psychiatric** issues? |
| [ ] Psychiatric diagnosis | [ ] Depression | [ ] Suicidal thoughts | [ ] Bipolar disorder | [ ] Homicidal ideations | [ ] Schizophrenia |
| [ ] Psychiatric hospitalizations | [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **endocrine** issues or procedures? |
| [ ] Thyroid disease | [ ] Hormone replacement therapy | [ ] Injectable steroid replacements | [ ] Diabetes |  |
| [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **hematologic/lymphatic** issues? |
| [ ] Anemia | [ ] Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) | [ ] HIV Positive | [ ] Abnormal bleeding/bruising |
| [ ] Sickle-cell anemia | [ ] Enlarged lymph nodes | [ ] Hemophilia | [ ] Hypercoagulation or deep vein thrombosis/history of blood clots  |
| [ ] Anticoagulant therapy | [ ] Regular aspirin use | [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **allergic and immunological** issues? |
| [ ]  Anaphylaxis (history of sneezing) | [ ] Food intolerance | [ ] Itching | [ ] Nasal congestion | [ ] Sneezing |
| [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Have you had any of the following **renal** issues or procedures? |
| [ ] Renal calculi/stones | [ ] Hematuria (blood in the urine) | [ ] Incontinence (can’t control) | [ ]  Bladder infections |
| [ ] Difficulty urinating | [ ] Kidney disease | [ ] Dialysis | [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] None of the above |
| Is there anything else in your medical history that you feel is important to your care here? |  |
|  |
| I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Morgan Chiropractic, Inc. to provide me with chiropractic care, in accordance with this state’s statutes.  |
| *Patient Signature:*  |  | *Date* |  |



Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

Area of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of pain (1 being lowest and 10 highest): \_\_\_/10

**HIPAA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. “Protected Health Information” is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician’s practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:**  Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

|  |  |  |  |
| --- | --- | --- | --- |
| *Patient Signature:*  |  | *Date* |  |

**Email Notification Form (Optional)**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow Morgan Chiropractic, Inc. to send me email notifications of office updates, events, and closures.

We will not give your email address to third parties. If at any time you wish to cancel this subscription, please email our office at morganchiro@gmail.com or call our office at (907) 646-2211 and we will remove you from our email list.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_